CLINICAL OPERATIONS
AT THE DECKPLATE

VOLUME 1, ISSUE 2 MAY 2008

UNDERSTANDING THE NEW PERFORMANCE-BASED BUDGET

CDR Annette Von Thun, MC *BUMED*

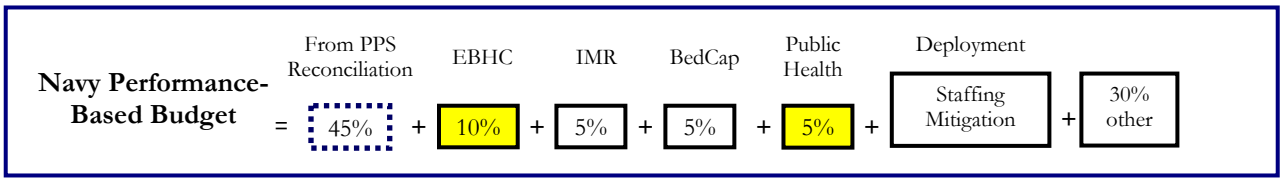


Figure 1

Similar to many civilian healthcare organizations, Navy Medicine has adopted a pay for performance model. In the fall of 2008, BUMED announced their Performance-Based Budget. In addition to the "basic block of money" received from the Prospective Payment System (PPS, capitation system), additional funding is based on the MTF's ability to address Evidence-Based Health Care (EBHC) measures, Individual Medical Readiness (IMR) compliance, Bed Capacity staffing ratios, and Public Health programs (see Fig 1). Unlike other incentive-only systems, performance on BUMED's PBB can either help or hurt a command's financial status.

Ten percent of an MTF's budget is dependent upon their performance on the EBHC measures. The EBHC measures that are currently being tracked in the PBB include the HEDIS measures that are incorporated into the Tri-Service Business Plan. These HEDIS measures are: Asthmatics with Long-Term Controller Medications, Diabetics with an A1C, Diabetics with an A1C $\leq$ 9.0, Diabetics with LDL < 100, and Women (age 52-69yo) with breast cancer screening. Two additional measures, that are currently in the business plan, but are being "shadowed", colon and cervical cancer screening, are expected to be included this summer.

To determine a command's reimbursement for the EBHC measures, each MTF is graded on their performance as compared to the HEDIS 75th and 90th percentile benchmarks. If a command is performing below the respective HEDIS 75th percentile a command gets "0" points; if they are performing greater than the 90th percentile they earn "1" point. Partial credit (0.5 points) is given for commands performing in this middle range. The number of points are tallied and their cumulative score determines +/- 10% of their budget.

The data to determine EBHC performance is completely transparent. EBHC data is derived from the Population Health Navigator (PHN). The PHN not only calculates an MTF's performance on the HEDIS measures, but provides the action lists of patients that aren't currently meeting the necessary standards. Even if you don't have a PHN account, the PHN dashboard (link below) allows commands to see their current performance as compared to other commands, the Navy average, and HEDIS benchmarks.

BUMED is also focusing on Public Health measures in three areas which will determine up to 5% of an MTF's budget. The PBB in FY09 will include Public Health measures that focus on 3 areas. The first area will be compliance with the Physical Readiness program which will assess compliance with PRIMS reporting and the number of individuals who have two consecutive PRT failures. The second topic will focus on healthy weight and will measure enrollment and course completion rates in ShipShape, the Navy's weight management program. The third Public Health focus will be Tobacco Cessation which evaluates the number of patients that are screened, diagnosed and counseled for tobacco cessation. The specifics of these pending Public Health measures and the PBB are awaiting mid-year review and may be subject to change.

Additional information for the PBB can be found at: https://nmo.med.navy.mil/pbb/.

To see your command's EBHC performance without a PHN account, the PHN dashboard is located at: https://dataquality.med.navy.mil/reconcile/pophealth/. ❖

INSIDE THIS ISSUE

2008 Disease Management Training A Success!

The 2008 Disease Management Training was held in conjunction with the annual Public Health Center's Preventive Medicine & Occupational Health Conference in Hampton VA on March 14-17. Over 150 attendees participated in the 13 half-day sessions that featured 33 speakers. Highlights of the opening session included a welcoming address by RDML Flaherty and an introduction to the Performance-Based Budget. Dr. Jerry Penso from Sharp-Rees-Stealy was the key note speaker addressing clinical quality and pay for performance initiatives in the civilian setting. Updates were also provided for Disease Management, AHLTA and Clinical Preventive Services.

The BUMED Tobacco Cessation Action Team presented a session discussing the many aspects of implementing tobacco cessation programs in the clinical setting—a new emphasis that complements current health promotion efforts. In addition to a session dedicated to community updates, the Diabetes Action Team hosted the ADA/AADE Diabetes Educator Training. The Asthma Action Team provided a community update, a spirometry course that provided hands-on training and a full-day asthma educator course geared toward improving nurse educator competency. An entire session was also devoted to medical informatics to include AHLTA, the Clinical Data Mart and Population Health informatics systems. Despite occurring over the weekend, these information-packed sessions were well-attended and allowed for great networking. This forum provided the opportunity to learn of current progress and future directions in the many arenas of Disease Management. ❖

Important Events

- **Tobacco Cessation Action Team**
  June 16th -17th @ San Diego, CA
- **Oral Health Advisory Board**
  June 18th @ Bethesda, MD
- **AHLTA Clinical Advisory Board**
  June 23rd -25th @ Washington, DC
- **Evidence-Based Healthcare Advisory Board**
  July 17th -July 18th @ San Diego
- **Diabetes Action Team**
  July 24th -25th @ San Diego
- **Navy Pharmacy Advisory Board**
  August 19th -22nd @ Little Creek, VA
- **Asthma Action Team**
  September 8th -12th @ Jacksonville, FL
- **Perinatal Advisory Board**
  September 15th -19th @ Washington, DC

New Disease Management Toolboxes Are Available

During the 2008 Disease Management Training held in March, the BUMED Diabetes (DAT), Asthma (AAT) and Tobacco Cessation Action Teams (TCAT) showcased their new Disease Management Webpages. Located on the Public Health Center's Website, these Webpages provide clinical and administrative resources for the provider and healthcare teams without passwords or CAC restrictions. These 25 Webpages provide guidance addressing best practices, clinical practice guidelines and metrics, provider and healthcare team training materials, patient education, practice reengineering, admin and policy. These Webpages can be found at:

- **Asthma Action Team (AAT) Resource Toolbox:**
  http://www-nmcphc.med.navy.mil/prevmed/asthma/index.htm
- **Diabetes Action Team (DAT) Resource Toolbox:**
  http://www-nehc.med.navy.mil/prevmed/asthma_diabetes/diabetes/index.htm
- **Tobacco Cessation Action Team (TCAT) Resource Toolbox:**
  http://www-nehc.med.navy.mil/hp/tcat/index.htm

How Do I Receive the Clinical Operations Newsletter? To receive the quarterly Clinical Operations Newsletter, please email Leanne.Repko@med.navy.mil to be included on the distribution list. Thank you!

BUMED's Corner

Autism Screening Tool Available in AHLTA

According to the Centers for Disease Control and Prevention (CDC), about 1 in 150 children have an autism spectrum disorder (ASD). Therefore, the American Academy of Pediatrics (AAP) recommends screening for autism at the 18 or 24 month well child visit using a recommended tool such as the Modified Checklist for Autism in Toddlers (M-CHAT). This survey consists of 23 "yes and no" questions, which should be completed with parents at this visit. Version 1 of M-CHAT in AHLTA is available at the enterprise level in AHLTA in Patient Questionnaires, by selecting "Interview", and then "Enterprise" for a complete list. The last question indicates whether there is a need for further evaluation. Instructions to score the completed M-CHAT questionnaire are available at http://www.firstsigns.org/downloads/Downloads_archive/m-chat_scoring.PDF

The M-CHAT should be coded as a Procedure by saving to Procedure Favorites, adding to Well Baby templates, or typing 96110 for CPT Search. Keep in mind that the relative value units (RVUs) associated with this CPT code for screening does not cover physician time. This screening should be administered (explained to parent and screening copy scored) by clinic staff, while the primary care clinician interprets the results. The recommended RVU codes to use with 96110 CPT code include*:

1. **99393-25** for preventative service visit (well child check-up). Proper code to use if payer does not "bundle" screening into preventative service.
2. **99213-25** for evaluation and management service with screening, or **99214-25** if additional concerns about the child's health status/developmental attainment resulted in a longer "time" for the visit
3. **99244-25 (**or **99245-25**) evaluation and management consultation service with screening
4. **99214-25** evaluation and management visit with screening instruments previously completed by child's parent or guardian.

**American Academy on Pediatrics, Section on Developmental and Behavioral Pediatrics Newsletter. Fall, 2007.*

Positive M-CHAT screens should be referred to a specialist for further evaluation. For more information, visit: http://www.dbpeds.org/articles/detail.cfm?TextID=377. ❖

How Do I Access...

Periodic Health Assessment (PHA) Toolkit?

The PHA toolkit provides ready, easily accessible PHA support to providers of all levels engaged in PHA. This includes supporting policies and references; necessary forms, flow charts and resources; patient education handouts; staff training materials, and various health risk assessments (Fleet and Marine Corps, Framingham, BMI, Clinical Preventive Services).

Directions for accessing the PHA Toolkit portal:

1) Login to NKO
2) On the Organizations & Communities drop down menu click on Communities of Practice.
3) Click on Navy Medicine
4) Click on Periodic Health Assessment-this will take you to the page.
5) Remember to bookmark the page for future use.

https://wwwa.nko.navy.mil/portal/page?paf_pageId=pg117500015

UpToDate on NMO?

Directions for accessing **UpToDate** via user name and password.

1. Go to the NMO Web site at http://navymedicine.med.navy.mil
2. Select "Clinical Resources" link one the menu on left
3. Select "Clinical Informatics & Evidence-Based Resources" link from the new menu
4. Select "UpToDate" from the menu that appears
5. A page appears asking for username and password. Enter as follows (case sensitive):
   a. **Username**: Uptodate
   b. **Password**: M@gic12
   c. **Select"**" Login" button
6. "UpToDate startup" screen will be displayed. Click "Accept" to proceed to the database.

Learn About Vaccines & Earn CMEs

The Vaccine Quarterly is a continuing education publication, which provides up-to-date clinical and research information on vaccines intended to improve care of pediatric patients. The publication includes literature reviews, clinical articles and letters from the editors.

- Vaccine Quarterly has ***free online access***
- Vaccine Quarterly provides ***free CE credit for physicians***.

www.vaccinequarterly.com

EBHAB Seeking New Membership

BUMED is seeking representatives from the **General Surgery, Internal Medicine,** and **Pediatrics** communities as well as an **MSC with clinic experience** to fill vacancies on the Evidence-Based Healthcare Advisory Board (EBHAB). We are interested in recruiting MOTIVATED clinical staff members who are interested in contributing to the improvement of evidence-based healthcare.

The EBHAB has been an advocate for evidence-based medicine and seeks to improve health outcomes by promoting the delivery of quality health care using evidence-based strategies throughout Navy Medicine. **The key mission elements of this multi-disciplinary BUMED-chartered Advisory Board include:**

- **Communicate** key evidence-based healthcare messages to clinicians, administrators and patients.
- **Advise** BUMED on issues pertaining to clinical performance improvement, disease management and evidence-based healthcare.
- **Establish** collaborative relationships with clinical advisory boards, specialty leaders, and others charged with improving care within Navy Medicine and in the MHS.
- **Support** a larger population health initiative by serving as experts on evidence in the development and analysis of performance measures.

BUMED funds the EBHAB to meet quarterly at various locations, lasting 1.5 to 2 full days depending upon the agenda. Interim meetings will be conducted by video conference and/or teleconferences as required. There is typically minimal workload between meetings. Membership is open to all CONUS personnel (GS/AD) with a background and interest in advancing evidence-based healthcare issues and working towards potential solutions. Membership is for a 24-month period. Individuals should send their CV and a statement of interest addressing their experience with relevant outpatient primary care experience. **Command acknowledgement/ endorsement** (i.e. informal email) of your availability and interest is sought.

If you'd like to make a difference and have some impact upon Navy Medicine, please consider applying! Submissions should be forwarded by **COB June 17** to Leanne Repko via email: Leanne.Repko@med.navy.mil ❖

SAP Update

Request For SAP Study Topics

The MHS Scientific Advisory Panel (SAP) is a Tri-Service level committee spearheaded by TMA's Office of the Chief Medical Officer as part of the Clinical Quality Management contract. The purpose of the SAP is to perform special clinical studies to assess the quality of care provided within the MHS through external reviews of care. The results of these studies are published on the MHS CQM website, condensed into fact sheets and created into educational modules.

The SAP is currently soliciting topics for consideration for their FY09 studies. Previous topics have included prenatal care, depression, heart failure, hypertension, PTSD, asthma, diabetes, & preventive services. A full listing of topics can be found at: https://www.mhs-cqm.info/Open/Education/Factsheets.aspx.

Proposals should include topics that are of broad relevance to the population served and should assess patient outcomes and/or the delivery of quality care. If you have an idea that you'd like to offer for consideration, please provide the topic & clinical quality question and/or concern to be addressed. Your suggestion should be submitted via email to CDR Annette M. Von Thun (Navy SAP representative) by **June 10** at annette.vonthun@med.navy.mil.

Advertise Your Success!

Office of the Chief Medical Officer, TMA is sponsoring a Healthcare Innovations Program (HIP) Award and Poster Exhibit, which will be offered in conjunction with the annual Military Health System (MHS) Conference scheduled December 1-4, 2008. The goal is to showcase MHS innovations and best practices that directly support the MHS Strategic Plan and to link people with ideas. TMA is looking for "transformational" innovations in Access, Cost, Effective Patient Partnerships, Healthy Lifestyles, Quality, and Readiness. They are accepting submissions (posters and abstracts) from June 23 through August 15 with awards for individuals in each category. Visit http://www.tricare.osd.mil//OCMO/innovations.cfm for more information.

Web Reminder System Sends Emails To Patients!

Help your patients to remember to come in for their clinical preventive services! The College of American Pathologists has a web-reminder system that allows patients to receive emails reminding them of blood donations, cholesterol and diabetes blood tests, and colon, cervical & breast cancer screening. Individuals can choose any date they like, and a message will be sent to the e-mail address of their choice. Encourage your patients to sign up for e-mail reminders today!
http://myhealthtestreminder.org/index2.cfm?langid=1

WHO ARE NAVY CASE MANAGERS?

Case Management, *BUMED*

In Navy Medicine today, approximately 150 licensed nurses and/or licensed social workers act as Navy Case Managers to meet the needs of active duty service members (ADSMs), their families and all other TRICARE Prime beneficiaries. Case Managers work with clients who require significant care coordination, advocacy, education and resource management to meet desirable health outcomes. A recent Navy report showed 4,856 clients are case managed; an estimated 30% of these patients are ADSMs with war related injuries. The expectation is the number of Case Managers will continue to increase each year as the health care team becomes more aware of the value of the Case Manager.

Frequently the Case Manager provides services for wounded warriors and their families. Care starts during acute hospitalization and continues as the patient transitions to the various levels of care, e.g. an inpatient rehabilitation program, another military facility, a skilled nursing facility or home. An integral member of the healthcare team, the Case Manager helps the injured service member adjust to his or her injuries and altered life status. As the patient moves through the continuum of care, they assist in the identification of patient and family needs and interventions to address those needs as well as the development of a plan of care agreed upon by the patient and/or family member. Case Managers also assist in benefit coordination and identification of resources. The Case Manager also communicates with care providers and discharge planners coordinating needed services to allow the service member to receive care, e.g. rehabilitation, closer to home, family or friends. The service member is able to continue in a day rehabilitation program to increase strength, stability, mobility and cognitive functioning while enjoying the care and support from family and friends. Patients with children can be an integral part of the child's life while undergoing therapy. Frequently the Case Manager is called into assist the patient obtaining VA benefits impacting the long term care plan. In a recent case, a retired service member had significant praise for a Case Manager and said, "… she knocked down roadblocks and moved mountains providing the specialized care I needed…"

Navy Case Managers are working with clients with chronic illnesses or more acute concerns such as multiple traumas sustained from motor vehicle accidents, premature infants, and high-risk pregnancies. By collaborating with clients, health providers, families and other support systems, including community-based programs, the Case Manager improves health outcomes and encourages optimal self-management. For example, a Case Manager assisted an elderly diabetic widow obtain food stamps and a VA pension. This intervention allowed her to meet financial obligations. Also, this improved her compliance taking insulin and following the appropriate diet. She now monitors her blood sugars, is compliant with her diet and exercise program. Supporting compliance with treatment improves the client's health status and supports the Commands HEDIS score for Hemoglobin A1c measure.

TALK, LISTEN, CONNECT

While assigned to the new Defense Center of Excellence for Psychological Health and Traumatic brain injury, CDR Russell Shilling, an Aerospace Experimental Psychologist, helped launch a program with Sesame Street to help children adjust to a parent changed by psychological or physical injuries received in combat. He was assisted throughout the process by LT David Gribben, MSC. The program additionally helps children deal with the stresses of deployments and multiple deployments. The Sesame Street resources consist of a bilingual (English/Spanish) multimedia outreach kit with DVDs for children and adults starring the Muppets from Sesame Street and interviews with military families who are coping with issues related to deployments and/or injuries.

The kits contain print materials for children, parents, caregivers and facilitators. Sesame Workshop will produce and distribute 400,000 kits via Military OneSource to individual families, schools, child care programs, family support programs, hospitals, rehabilitation centers and other organizations serving the needs of military families. All materials may also be downloaded at http://www.sesameworkshop.org/tlc/.

JOINT COMMISSION CONFERENCE SHARES KNOWLEDGE

The Third Annual Joint Commission/Navy Medicine Conference was held April 28-May 2, 2008 in Chicago with all commands represented. The Joint Commission program focused on accreditation process changes for 2008-2009, changes in standards, National Patient Safety Goals, and successful program implementation and sustainment. The Navy Medicine program focused on Navy specific topics in performance improvement, risk management, and patient safety. Keynote speakers were Captain Bruce Gillingham, Deputy Commander at Naval Medical Center Portsmouth, speaking on "Engaging Leaders in Patient Safety" and Ms. Marcy Auclair, BUMED Attorney Advisor for Health Law, who spoke on "Current Topics in Legal Medicine."

Both Navy and The Joint Commission programs were well-received and provided up-to-the minute information from subject matter experts. If you have any questions about upcoming changes in the accreditation process or standards:

- Visit www.jointcommission.org
- Contact Captain Linda Grant, BUMED Joint Commission Clinical Specialist, at linda.grant@med.navy.mil.

Improving health outcomes is one of the most important things Case Managers do to support the goals of Navy Medicine. In a future newsletter, highlights of how case managers support additional goals of Navy Medicine such as cost containment will be described. To refer a potential client to case management, simply contact the Case Management Department head at your Navy Hospital or Branch Clinic by phone to describe your case management needs.

DISEASE MANAGEMENT

AAT Webcast Training

Asthma Webcasts to start in August!

The BUMED Asthma Action Team (AAT) will be sponsoring Asthma disease management training starting in August. This lecture series will alternate with the DAT Webcasts currently being offered on the 1st Tuesday of the month. The first AAT Webcast will be presented on **August 5th** by CAPT Henry Wojtczak (NMC San Diego) entitled, **"Highlights of the Updated NHLBI & DoD/VA Clinical Practice Guidelines"**. Sessions will be offered several times throughout the course of the day (to allow maximal participation by all commands throughout Navy Medicine). The Webcast will be available at https://connect.dco.dod.mil/aatwebcast. Dial in access for audio will be available closer to the date of the Webcast. Mark your calendars now for these exciting training opportunities!

Future Webcast Training Schedule:

- Oct 7th, 2008: **Asthma Action Plans & Patient Education Tools**
  Presented by: LCDR Lance Potter
- Dec 2nd, 2008: **Asthma Devices**
  Presented by: CDR Rees Lee

BE PREPARED: USE END-OF-YEAR FUNDING FOR SPIROMETERS

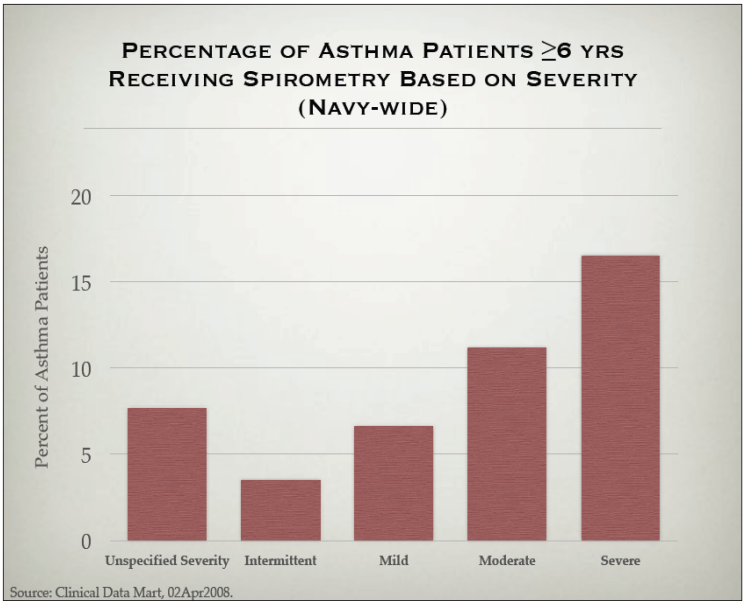
Based on the new NHLBI and DoD/VA clinical practice guidelines (CPGs), spirometry plays a more prominent role for the diagnosis and management of asthma. Spirometry is recommended 1) at diagnosis, 2) following treatment initiation in order to document clinical response, 3) periodically (every 1-2 years) as a means to monitor for progressive changes in pulmonary function, and 4) as clinically indicated during periods of poor asthma control.

Unfortunately, spirometry care is not uniformly provided throughout Navy Medicine. Recent analysis of data suggests that only a small portion of asthma patients seen at Navy facilities undergo spirometry. All clinics need to have a process to provide spirometry services for their beneficiaries—either by direct care or via referral for network care—and need to meet TRICARE access standards.

The AAT recognizes that some clinics do not currently have the capabilities or resources to meet these more rigorous spirometry standards. Thus, the AAT is recommending that commands prepare for the usual surplus of end-of-year funds should they become available to their MTF. Primary care clinics should plan ahead by creating funding requests for spirometers to potentially include staff training and/or supplementary personnel to accommodate these additional requirements.

Asthma Program Assessments

The AAT's assessing current capabilities, practices, and patterns of care for asthma programs at the various MTFs through 2 questionnaires. The first questionnaire targets Population Health Managers for an overview of their command's Asthma Program. The second questionnaire targets all providers who treat asthma patients. This anonymous survey should take approximately 10 minutes to complete. The AAT would appreciate your feedback in assessing the current status of asthma programs in Navy Medicine. The website for the PROVIDER questionnaire is: https://nmo.med.navy.mil/survey/?survey_id=814.



Recent assessment of the use of spirometry by Navy providers demonstrates that even in the most severe asthma patients, spirometry is only ordered < 20% of the time.

CHOOSING A SPIROMETER?

The AAT has evaluated a variety of spirometers on the market and has assessed their cost, ease of use, portability, appropriateness for the pediatric population and exportability to AHLTA. Although there a few commendable products, the KoKo® spirometers were highly recommended and were found to be cost-effective and applicable to the MTF clinic setting.

For spirometry resources, to include the spirometry comparison chart and KoKo® product information, please refer to the AAT toolbox and look under "Spirometry & Other Devices" at: http://www-nmcphc.med.navy.mil/prevmed/asthma/index.htm .

Also see, "Clinical Practices Guidelines" for the links to the NHLBI and DoD/VA CPGs.

PreDiabetes Position Statement for Adults

LCDR Patrick Clyde, MC *NNMC Bethesda*

The BUMED Diabetes Action Team (DAT) is pleased to announce the creation of a position statement, which recommends a process for screening and treating of PreDiabetes in Adults. The DAT agrees with the position statement of the American Diabetes Association (ADA) on the prevention and delay of diabetes and makes the following recommendations with regards to screening for prediabetes in adults:

1. Individuals who should be screened for impaired fasting glucose (IFG) or impaired glucose tolerance (IGT):
   a. Men and women ≥45 years of age, particularly those with a BMI ≥25 kg/m^2
   b. Consider screening in younger individuals with a BMI ≥25 kg/m^2 with diabetes risk factors, such as:
      i. First-degree relative with diabetes
      ii. Habitual physical inactivity
      iii. Member of a high-risk ethnic population
      iv. Previously identified prediabetes (IFG or IGT)
      v. History of gestational diabetes or delivery of a baby weighing >9 lbs
      vi. Hypertension (≥140/90 mmHg)
      vii. HDL cholesterol level ≤35 mg/dL and/or a triglyceride level ≥250 mg/dL
      viii. Polycystic Ovarian Syndrome
      ix. History of vascular disease
   c. If negative, consider repeat screening three years later.
2. Individuals with IFG or IGT should be intensively counseled to lose weight and exercise.
3. Lifestyle changes are twice as effective as most drug therapy. Medications should NOT be routinely used to prevent diabetes until more information is known about its safety and cost-effectiveness.
4. Metformin, titrated up to 850 mg twice daily, should only be considered in the subset of adults with demonstrated IFG *and* IGT if they have the diabetes risk factors listed above *and* they are <60 years of age, BMI ≥35, and an A1C>6.0%.

To view the position statement in its entirety, including a full-size algorithm depicting the screening and treatment process (see reduced diagram in Figure 2), access the DAT Toolbox:

http://www-nehc.med.navy.mil/prevmed/Asthma_Diabetes/Diabetes/DATPre-Diabetes.doc

Additionally, obesity resources to assist with addressing lifestyle modifications can be found on the DAT Toolbox under "Healthcare Team Resources."

http://www-nehc.med.navy.mil/prevmed/Asthma_Diabetes/Diabetes/index.htm

DAT Webcast Training

Disease Management Training: Insulin Pumps

The Diabetes Action Team (DAT) announces the next in its series of webcasts to be presented on **July 8th**. CDR Amir Harari, MC (NMC San Diego) will be providing a presentation entitled, **"Pumping Insulin: Starting Your Own Program"**. This lecture will review pump mechanics, good candidates for referral, converting patients to a pump insulin regimen, and essential teaching points for patients.

Sessions will be offered several times throughout the course of the day (to allow maximal participation by all commands throughout Navy Medicine), archived for future access, and will provide CME/CEU credit. The Webcast will be available at https://connect.dco.dod.mil/datwebcast Dial in access for audio will be available closer to the date of the Webcast.

Pacific	Eastern	Europe	Asia
6am	9am	3pm	(10pm)
9am	12pm	6pm	(1am)
3pm	6pm	(12mn)	~7am

Future Webcast Training Schedule:

- Sept 9th, 2008 **Cardiovascular Risk Reduction** Presented by: Nahed Bahlawan, PharmD (NH Camp Pendleton)
- Nov 4th, 2008 **Nutrition**
  Presented by: LT Tinsika Riggs, RD (NH Lemoore)

❖ Previous DAT Webcast presentations are now archived and can be found in the DAT Toolbox: http://www-nehc.med.navy.mil/prevmed/Asthma_Diabetes/Diabetes/Diabetes_HTM.htm

❖ We'd love to hear what you think of the DAT webcast! Take their survey at: https://nmo.med.navy.mil/survey/default.cfm?survey_id=843

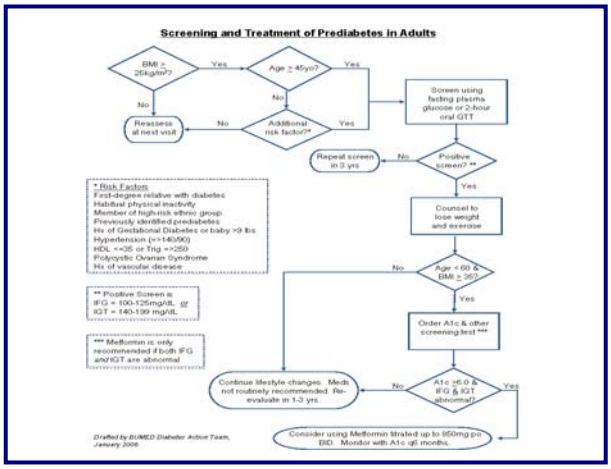


Figure 2

Tobacco Cessation Position Statements Just Released!

CDR Annette Von Thun, MC *BUMED*

The BUMED Tobacco Cessation Action Team (TCAT) is pleased to announce the creation of position statements delineating the roles of the various stakeholders who participate in the provision of tobacco cessation services.

TCAT encourages all members of the healthcare team (medical, dental, pharmacy, SARP and health promotion staff) to take an active role in tobacco cessation, including counseling intervention (5A's: Ask, Advise, Assess, Assist, Arrange), referral and the prescribing of medications when needed. A public health model that reaches out to the entire Navy/Marine Corps population is the recommended approach to achieving these goals.

In order to provide population and evidence-based tobacco programming, it is essential to remove barriers to pharmacotherapy use by not restricting medications via participation with formal health promotion classes. Based on the DOD/VA CPG and using a population health and continuum of care model, patients should be provided interventions based on their clinical assessment. Providers need to recognize those patients who require more intensive intervention, to include health promotion or other adjunctive modalities (e.g., mental health, substance abuse clinics).

Health Promotion (HP)-- HP plays an instrumental role in a clinic's ability to provide Tobacco Cessation (TC) services to our patients. HP serves as the chief advocate for tobacco prevention, education and cessation services and efforts. Navy Medicine recognizes that one person cannot provide all the necessary care and interventions for their respective beneficiaries. The HP staff (and our Semper Fit colleagues) will work collaboratively with providers in the MTF, along with community groups, to provide tobacco prevention and cessation programs.

Pharmacy—Pharmacy plays an important role in a clinic's ability to offer care (including TC intervention) to our patients, by providing additional patient education and ensuring compliance based on medication usage and refill history. Pharmacists can play a more active role in becoming tobacco cessation facilitators and teaching many of the health promotion/wellness classes. Additionally, clinical pharmacists can become physician extenders and actively prescribe in the setting of a clinical practice agreement, similar to coumadin clinic.

FUN FACT! On average, 300 students graduate from the Naval Hospital Corps School (NHCS) ***every month*** with tobacco cessation education skills.

The Tobacco Cessation Process: Many Hands Make Light Work

CAPT Larry Williams, DC *NH Great Lakes*

Everyone in Navy Medicine should feel that they have a role in the tobacco cessation process. Given this, we must not forget the significant impact that our primary care support staff can have in facilitating tobacco cessation. Every staff member should be empowered to engage in the basics of tobacco cessation. At a minimum this should be to "Ask" each beneficiary about their tobacco use at any available opportunity. No one should feel "it is not my job". The more we "Ask", the more chances our beneficiaries can have at entering the cessation process.

An example of this "basic" tobacco cessation opportunity is an ongoing educational process at the Naval Hospital Corps School (NHCS). The BUMED Tobacco Cessation Action Team (TCAT) has worked with NHCS instructors to create a basic educational program for newly graduated Corpsmen. This program explains the basics of the five "A's"- Ask, Advise, Assess, Assist, and Arrange consistent with the DoD/VA Clinical Practice Guideline for Tobacco Use Cessation. It also helps discuss how corpstaff can effectively interact with beneficiaries in any medical or dental setting.

Due to the tremendous adverse cost of tobacco on the DoD, we must get everyone involved in the cessation process. Over 60% of current tobacco users want to quit. It is only by asking, that we can determine who is ready to take the next step. This new corpstaff training module is available for other commands in the TCAT toolbox located at: http://www-nehc.med.navy.mil/hp/tcat/Training.htm. Please contact CAPT Larry Williams at Larry.Williams@med.navy.mil if you would like additional information.❖

Dental-- As part of the Navy's healthcare team, Navy Dentistry plays an important role in tobacco cessation interventions since a) tobacco use directly and adversely affects oral health; b) tobacco cessation counseling can be incorporated into annual dental readiness encounters IAW Navy policy; and c) opportunities exist for tobacco counseling with dental procedures often associated with negative outcomes of tobacco use. The harm generated from the use of tobacco is easily integrated into this oral health teaching. This is especially true for procedures such as oral regeneration (tobacco-related periodontal disease), tooth whitening (tobacco-related staining), and implants (tobacco-related oral disease).

To see these and other position statements, refer to the TCAT Toolbox: http://www-nehc.med.navy.mil/hp/tcat/BP.htm ❖

PERINATAL CARE

MILITARY AND SURROGATE MOTHERS

There has been concentrated media attention on an important topic in military healthcare: surrogacy and military wives (such as the Newsweek article *Curious Lives of Surrogates*, published April 4, 2008). Such stories focus on the lives of these women who choose to be surrogates, as well as the debate over TRICARE health insurance paying for the surrogacy-related medical costs. Here is some helpful information from the BUMED Women's Health office to understand TRICARE benefits as it relates to surrogate coverage. Please use this information as a resource to educate yourself, as well as to answer any questions that others may have.

- Does TRICARE cover a surrogate's medical expenses during her pregnancy?
  - Contractual arrangements between a surrogate mother who is eligible for TRICARE coverage and adoptive parents are considered other health insurance coverage. It is a statutory obligation that the government has the right to recover funds expended on such claims. The law requires DoD to recover from third party payers the reasonable costs of health care services incurred on behalf of such a person. Traditionally surrogate contracts provide for the reimbursement of health care costs, thus they are considered to be third party payers for purposes of reimbursement to the US. See the TRICARE Reimbursement Manual, Chap. 4, Section 4, Paragraph XVI.

- What if no specific monetary amount is in the surrogate contract?
  - In this case, the full amount of all undesignated payments shall be deemed to be for medical expenses incurred by the surrogate mother. The other health insurance coverage would cover these expenses; with TRICARE cost sharing on the remaining balance of otherwise covered benefits.

- What if there is no other health insurance available for cost-sharing?
  - TRICARE is committed to caring for the health of our beneficiaries. TRICARE covers medical services and supplies related to conception and delivery, including prenatal and postpartum care (generally through the sixth post-delivery week), and treatment of pregnancy complications. The cost of care for the newborn, who is not a TRICARE beneficiary, is the responsibility of the adoptive parents.

- If a woman (TRICARE beneficiary such as a female sailor or Navy wife) wishes to be a surrogate mother, that is, carry someone else's fertilized embryo to term, would her maternity care be covered by TRICARE?
  - Military members are bound by regulations other than TRICARE policy. Active Duty members should look to their own service regulations to determine whether they may become a surrogate for someone else.

- For a military couple in which the wife was unable to carry a baby -- if they recruited a surrogate mother, would the couple's prenatal care be covered by TRICARE?
  - The costs of the surrogate's care in this case would not be covered because the surrogate mother is not a TRICARE beneficiary and so is not entitled to care in the MTFs or by civilian providers.

- For more information, contact TRICARE:
  - Austin Camacho, Public Affairs, TRICARE Management Activity
  - Bonnie Powell, Public Affairs, TRICARE Management Activity

"DID YA KNOW?"

MILITARY SALUTE WHEN NOT IN UNIFORM

The National Defense Authorization Act for FY2008, signed by the President, states, "all persons present in uniform should render the military salute. Members of the Armed Forces and veterans who are present but not in uniform may render the military salute. All other persons present should face the flag, stand at attention with their right hand over the heart, or if applicable, remove their headdress with their right hand and hold it at the left shoulder, the hand being over the heart. Citizens of other countries present should stand at attention. All such conduct toward the flag in a moving column should be rendered at the moment the flag passes."

PERINATAL INFO YOU NEED TO KNOW!

- There's a new name in Navy Medicine – the Provider Re-Entry Program is now officially called the **Competency Sustainment Program.** Navy has representation on the STABLE National Faculty for Quality Assurance! CDR Con Yee Ling, MC (NMC San Diego), Chair for the Perinatal Advisory Board (PAB) has joined them as a member.
- Who Qualifies for ALSO and STABLE?
  - STABLE: All Nursery Staff (eg: providers, RN, HM, clinical support)
  - ALSO: All Licensed Healthcare Staff working in Labor and Delivery (eg: physicians, APN, RNs, etc)

We Highly Recommend for POEP and NOEP…

- **Perintal Orientation Education Program (POEP)** required for L&D, Post Partum, Antepartum, and Nursery Personnel
  - New orientees will take full didactic course
  - Experienced personnel may test out
  - Recommended for perinatal clinic personnel
- **Neonatal Orientation Education Program (NOEP)** required for NICUs
  - New orientees will take full didactic course
  - Experienced personnel may test out
  - Recommended for Level 2 Nurseries

PAB Report Card Timeline for POEP and NOEP

- **Orientees**
  - FY08: Orientees take 2 didactic courses
  - FY09: 25% of all Orientees compliant
  - FY10: 50% of all Orientees compliant
- **All Experienced Personnel**
  - FY08: 25% of all experienced personnel compliant
  - FY09: 66% of all experienced personnel compliant
  - FY10: 75% of all experienced personnel compliant

GUIDANCE FOR PERINATAL QUARTERLY REPORT CARD

Filling in all the metrics for the quarterly PAB report card can be confusing. Here are some tips for the next PAB report card. Address process improvement to improve measures that are lacking and follow-up with PAB to meet requirements.

1. PAB Report Card Deadlines
   a. 3rd Quarter: **End of June, 2008**
   b. 4th quarter: **End of September, 2008**
2. Run the report card responses through your chain of command. Your leadership at an MTF and regional level should know the metrics you report.
3. PAB expects that everyone will not be "green" in all the measures; we are tracking these metrics in order to identify barriers commands face while trying to reach requirements.

RECOMMENDATIONS FOR SCREENING FOR FETAL CHROMOSOMAL ABNORMALITIES

In January 2007, ACOG released updated guidelines for screening for fetal chromosomal abnormalities (ACOG Practice Bulletin #77). It emphasized that pregnant patients should be offered screening. However, it also make clear that no single strategy is appropriate for all locations or all patients.

Each facility should, based on the resources available, develop its own protocol for which screening tests to offer. At a minimum, all patients should be offered the maternal quad screen. Because the maternal triple screen is less sensitive than the quad screen, it is not an appropriate alternative.

MEDICAL INFORMATICS

POPULATION HEALTH NAVIGATOR (PHN) Q & A

How do I fix PHN errors?

- Some of the patients that on presumes are incorrectly diagnosed are in fact correct. If one only looks at AHLTA or the individual's outpatient medical record they aren't getting the "big picture". They may not be cognizant of those patients who have sought network care at other civilian providers or EDs or those who may have received medications that would qualify them for inclusion. In order to get the complete profile, have your command's M2 database person pull the SIDR/SADR (for MTF care), institutional/noninstitutional (for network care), and the PDTS files (for pharm data) to determine why these patients "ruled in" and are included on the PHN action list.
- If the patient was incorrectly coded during an outpatient/ED encounter (e.g., patient with gestational diabetes), the provider can go into the clinical encounter note and change the ICD9 code assigned to that patient. The PHN staff are working on creating a new document that demonstrates how to change ICD9 codes in AHLTA (can't use CHCS-1, because AHLTA will overwrite it)., but in that interval, check with your local coders to assist with modifying previous encounters.
- Some patients may appear on the action list that are no longer enrolled to your MTF. However, until those individuals re-enroll somewhere else, your command is responsible for them (financially, and "statistically"). Unfortunately, commands can't disenroll beneficiaries. There are two options available. OPTION 1: Have your command representative contact these beneficiaries directly to encourage them to reenroll at their new location. OPTION 2: There is new implementation guidance for Health Affairs Policy 06-007 that was signed Nov '07 that states that regional Managed Care Support Contractors (MCSC) can offer enrollment and reenrollment options to individuals that are outside the region, outside a 100-mile catchment area, or outside a 30-minute radius, dependent upon CO's discretion. TMA is in the process of modifying the current TRICARE contract to enable MCSCs to implement this program, but it offers commands some relief from the subset of beneficiaries who are outside the general catchment area but still elect to seek care at the MTF or who have moved but haven't yet selected a new primary care manager. Unfortunately, until these individuals reenroll at their new location or to the network, the command is "stuck" with them.
- Some commands report having deceased beneficiaries on their action lists. DEERS is the definitive data source, but the PHN actually uses a variety of mechanisms to exclude these individuals (to include the Social Security Death Index, discharge/disposition fields, etc.). So somehow there is a disruption in their local reporting processes (e.g., PSD) in reporting this data. PHN staff are currently exploring additional potential solutions, to include possible ICD9 fixes.
- A subset of patients are found on the action lists for preventive services that should otherwise be excluded (e.g., women with bilateral mastectomies no longer need routine mammography). Although the PHN uses DRG and CPT codes to exclude these individuals, these procedures may have predated our databases or may have been performed outside of our MTF system. In that case, a series of DoD-specific ICD9 codes can be used with physician encounters to capture these individuals for exclusion. For a complete listing of appropriate ICD9 codes please refer to the Feb 08 Clinical Operations newsletter.
- Of the subset of patients that changed diagnosis, or were incorrectly coded and for some reason the coding can't be modified... the good news is that these individuals will roll off eventually (generally a rolling 12-months). Which means you'll have to grin & bear it until then. (I know, not an answer you want to hear.) ☺
- Finally, if you truly think that there are some data inconsistencies, you can provide a list of names/SSN/etc (in a secure manner) and the folks at NMCPHC can assist you in tracking down what the issue is (see below). The Population Health Navigator is quite robust. Many of the concerns attributed to the PHN tool, are in fact (local) data quality issues. REGARDLESS, the NMCPHC can assist in determining what the problems are with the data quality, etc. so that you can more appropriately address those concerns.

For PHN assistance, contact the NMCPHC staff below. For more info on PHN tool, review PHN resource page and PHN FAQ's.

- http://www-nehc.med.navy.mil/prevmed/PopHealthNav.htm
- http://www-nehc.med.navy.mil/hp/PH_Navigator/FAQ.htm

If you'd like a copy of the HA Memo mentioned above, it hasn't yet been posted to the internet by Health Affairs/TMA yet. But contact CDR Annette M. Von Thun (Annette.VonThun@med.navy.mil) and she'd be happy to send you a copy.

POP HEALTH NAVIGATOR SUPPORT IS MOVING!

Management of the Population Health Navigator (PHN) program has been delegated to the Navy and Marine Corps Public Health Center (NMCPHC). NMCPHC will provide a HELPDESK service to assist in setting up and managing accounts and can be contacted at PHN-help@nehc.mar.med.navy.mil. The Program Manager at NMCPHC will assist customers in extracting and using information from the PHN tool, which provides both aggregate and detailed MTF level data. The PHN Dashboard is an aggregate display of MTF performance with respect to population health and evidence-based medicine metrics. Questions or problems related to Dashboard metrics should be referred to the Program Manager at NMCPHC, Dr. Steve Heaston, who can be contacted at steven.heaston@med.navy.mil or 757-953-0962, DSN 377.

WHO'S ON THE CLINICAL ADVISORY BOARDS?

AHLTA CLINICAL ADVISORY BOARD (ACAB)		
NAME	**LOCATION**	**ROLE**
CAPT Christine Boltz, NC	BUMED	Chair
CDR David Shapiro, MC	BUMED	BUMED Program Manager
CAPT Bart H. Knox, DC	BUMED	Dental
CAPT Robert Marshall, MC	BUMED	Family Medicine
CDR Margaret Beaubien, NC	BUMED	CIO
CDR Thomas Chupp, MC	NMC Portsmouth	Family Medicine
CDR Michael Hoffer, MC	NMC San Diego	Ear/Nose Throat
LCDR Brian Bowes, MC	NMSC Jacksonville	Internal Medicine
LCDR Michael Feeser, MSC	OPT	NHC Annapolis
LCDR Danahe Sierra, NC	NH Jacksonville	DNS

EVIDENCE-BASED HEALTHCARE ADVISORY BOARD (EBHAB)		
NAME	**LOCATION**	**ROLE**
CDR Annette Von Thun, MC	BUMED	Chair
CAPT Cynthia Grant, NC	BUMED	Quality Management
CAPT Robert Marshall, MC	BUMED	Family Practice
CAPT(s) Emory A. Fry, MC	NAVMED WEST	Navy Regional Representative
CAPT(s) Paul Rockswold, MC	NMC Portsmouth	Clinical Epidemiology
CDR Eric J. Kuncir, MC	NMC San Diego	Surgery
CDR Jacqueline Rychnovsky, NC	NMC San Diego	Nursing Research
CDR Jonathan Stahl, DC	NMC San Diego	Dental
LCDR Timothy Roberts, MC	NMC Portsmouth	Pediatrics
LT Bruce H. Thompson, MSC	BHC Portsmouth	Pharmacy
CAPT(s) Cynthia J. Gantt, NC*(ad hoc)*	TMA	TMA Representative
CAPT(s) Mark Stephens, MC*(ad hoc)*	USUHS	USU Population Health

ASTHMA ACTION TEAM (AAT)		
NAME	**LOCATION**	**ROLE**
CAPT Henry A. Wojtczak, MC	NMC San Diego	Co-Chair/Pediatric Pulmonology
CDR Rees L. Lee, MC	NMC Portsmouth	Co-Chair/Pediatric Pulmonology
CDR Annette Von Thun, MC	BUMED	BUMED Program Manager
CAPT Daniel E. Frederick, MC	NH Bremerton	Clinical Epidemiology/Population Health
CDR Andrew S. Johnson, MC	NMC Portsmouth	Emergency Medicine
CDR John T. Manning, NC	NH Camp Lejeune	Asthma Education
LCDR Christina Collura-Burke, MC	NMC Portsmouth	Allergy
LCDR Dermot Killian, MC	NMC Portsmouth	Adult Pulmonology
LCDR Lawrence H. Potter, MC	NH Jacksonville	Pediatrics
LCDR Brian Smoley, MC	NH Bremerton	Family Medicine
Ms. Nahed Bahlawan, PharmD	NH Camp Pendleton	Pharmacy
HM1 Charles Ragland (*ad hoc*)	NMC San Diego	Respiratory Therapy

DIABETES ACTION TEAM (DAT)		
NAME	**LOCATION**	**ROLE**
CAPT(s) Maureen O. Padden, MC	NavMed NCA	Chair/Family Practice
CDR Annette Von Thun, MC	BUMED	BUMED Program Manager
CDR Alan Douglass, MC	NMC San Diego	Endocrinology
LCDR Adolfo Granados Jr, MC	NMC San Diego	Family Medicine
LCDR William T. Scouten, MC	NMC Portsmouth	Pediatric Endocrinology
LCDR Julie Working, NC	NHC Patuxent River	Diabetes Educator
LT Patrick Turpin, NC	NH Twentynine Palms	MTF Nurse
LT David You, MC	NH Great Lakes	Internal Medicine
Nahed Bahlawan, PharmD	NH Camp Pendleton	Pharmacy
Barbara Nelson, RN	NH Pensacola	Population Health
LCDR James A. Ellzy, MC *(ad hoc)*	TRICARE Management Activity	Informatics Champion
LT Tinsika Riggs, MSC *(ad hoc)*	NH Lemoore	Registered Dietician

TOBACCO CESSATION ACTION TEAM (TCAT)		
NAME	**LOCATION**	**ROLE**
CAPT Larry N. Williams, DC	NH Great Lakes	Co-Chair/ Dental
Dr. Mark A. Long, PhD	NEHC, Portsmouth	Co-Chair/NMC PHC Health Promotions
CDR Annette Von Thun, MC	BUMED	BUMED Program Manager
CAPT(s) Joseph G. McQuade	NH Jacksonville	Primary Care
CDR William S. Padgett, MC	NAVAIR, Patuxent River	Fleet Provider
LCDR Daniel F. Seidensticker, MC	NMC San Diego	Internal Medicine/Cardiology
LT Jeff H. Cook, MSC	NNMC Bethesda	Mental Health
Martha J. Hunt	NH Twentynine Palms	Health Educator
CAPT Jo Ann Critelli, NC (*ad hoc)*	DETG	Reservist
CAPT Patricia Dorn, NC (*ad hoc)*	BUMED	BUMED Health Promotions
LCDR Eric R. Parsons, MSC (*ad hoc)*	BMC Bangor	Pharmacy
Nicole M. Ayan, MS, MCB (*ad hoc)*	NH Camp Pendleton	MCCS Semper Fit
John T. Vaughan *(ad hoc)*	NH Bremerton	SARP

NAVY PHARMACY ADVISORY BOARD (NPAB)		
NAME	**LOCATION**	**ROLE**
CAPT David Price, MSC	BUMED	Chair
LCDR Richard Masannat, MSC	BUMED	BUMED Program Manager
CAPT Stephanie M. Simon, MSC	NMC Portsmouth	Pharmacy
CDR Philip J. Blaine, MSC	NH Pensacola	Pharmacy
CDR Derrick Clay, MSC	NH Bremerton	Pharmacy
CDR Robert Fuller, MSC	NH Camp Lejeune	Pharmacy
CDR Scott Lawry, MSC	NMW, San Diego	Pharmacy
CDR Denise M. Leveling, MSC	NH Jacksonville	Pharmacy
CDR Edward C. Norton, MSC	NH Camp Pendleton	Pharmacy
CDR Ron Nosek, MSC	NNMC Bethesda	Pharmacy
LCDR Jay J. Peloquin, MSC	NMC Portsmouth	Pharmacy
LCDR Benjamin Schwartz, MSC	NH Twenty-Nine Palms	Pharmacy
LCDR Marc Young, MSC	DMSB, Ft. Dietrick	Pharmacy
LT David J. Sohl, MSC	NH Corpus Christi	Pharmacy
HMC James Forester	NMC Portsmouth	Pharmacy Technician
Ms. Kathy Gluzinski	NH Great Lakes	Pharmacy

ORAL HEALTH ADVISORY BOARD (OHAB)		
NAME	**LOCATION**	**ROLE**
CAPT Jeff Nordin, DC	NNMC Bethesda	Chair, Operative Dentistry
CDR Ken Green, DC	BUMED	BUMED Program Manager
CAPT Rick Freedman, DC	NBHC Oceana	Comprehensive Dentistry Representative
CAPT Gary Goodell, DC	NPDS	Endodontics Specialty Leader
CAPT Gerald Grant, DC	NPDS	Implant Dentistry Specialty Leader
CAPT Joseph Iannone, DC	FLTFORCESCMD	Fleet Operations
CAPT Craig Neitzke, DC	NPDS	Prosthodontics Specialty Leader
CAPT (Sel) Michael Steinle, DC	NNMC Bethesda	Oral Surgery Specialty Leader
CAPT Daryl Taylor, DC	HQMC	FMF Medical Office of the Marine Corps
CDR Francisco Leal, DC	BUMED	Business Planning
CDR Sean Meehan, DC	NPDS	Oral Medicine Specialty Leader
CDR Anthony Opilka, DC	NNMC Bethesda	Periodontics Specialty Leader
CDR Jonathan Stahl	NMC San Diego	Preventative Dentistry Specialty Leader
HMCS Magtanggol Stodomingo	BUMED	Enlisted Advisor Representative
CAPT John Johnson (*ad hoc*)	NNMC Bethesda	Oro-Facial Pain Specialty Leader
CAPT Kerry Krause (*ad hoc*)	BUMED	Reserve Affairs Representative
CDR Scott Curtice (*ad hoc*)	NMC San Diego	Orthodontics Specialty Leader
LCDR Glynn S. Spencer, DC (*ad hoc*)	NPDS	Pediatric Dentistry Specialty Leader

PERINATAL ADVISORY BOARD (PAB)		
NAME	**LOCATION**	**ROLE**
CDR Con Yee Ling, MC	NMC San Diego	Chair, Neonatology
LCDR Vanessa Richards, NC	BUMED	BUMED Program Manager
CDR Khin Aungthein, NC	BUMED	NICU & Maternal Child Nursing
CDR Trisha Farrell, NC	NH Bremerton	CNM
CDR William Leininger, MC	NMC San Diego	OB/GYN
CDR Jeffrey D. Quinlan, MC	NM Support Command	Family Medicine
CDR Timothy Shope, MC	NMC Portsmouth	Pediatrics
LT Jeffrey L. Gafner, MC	NNMC Bethesda	Anesthesia

PRIMARY CARE ADVISORY BOARD (PCAB)		
NAME	**LOCATION**	**ROLE**
LCDR Brian Bowes, MC	NH Jacksonville	Chair, Internal Medicine
CAPT Kevin Haws, MC	NH Beaufort	Pediatric Nursing
CAPT Ann M. Uetz, NC	NH Pearl Harbor	Family Nurse Practitioner
CDR Vincent L. DeCicco, MC	Deployed	Family Practice
CDR John W. LeFavour, MSC	NCHNE, Newport	CAN Administrator
LCDR Geraldine Holden, NC	BHC Sewells Point, Norfolk	Family Medicine
LT Benjamin Rodriguez, MC	NH Pensacola	Internal Medicine

How Do I Receive the Clinical Operations Newsletter? To receive the quarterly Clinical Operations Newsletter, please email Leanne.Repko@med.navy.mil to be included on the distribution list. Thank you!